Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

Medical Assistance Administration

SCHOOL MEDICAL SERVICES

For Special Education Students

Billing Instructions

(WAC 388-537-0100)

September 2000

About this publication

This publication supersedes all previous MAA School Medical Services for Special Education Students Billing Instructions.

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services
September 2000

Received too many billing instructions?
Too few?
Address incorrect?

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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How to Complete the HCFA-1500 Claim Form

Important Contacts

A provider may contact MAA with questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2))

Applying for a provider

Call:
(800) 562-6188 and
Select Option #1

or call one of the following numbers:

(360) 725-1026
(360) 725-1032
(360) 725-1033

Where do I send my claims?

Hard Copy Claims:
Division of Program Support
PO Box 9248
Olympia WA 98507-9248

Magnetic Tapes/Floppy Disks:
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

How do I obtain copies of billing instructions or numbered memoranda?

Check out MAA's web site at:
http://maa.dshs.wa.gov

Or write/call:
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
(800) 562-6188

Who do I contact if I have questions regarding…

Payments, denials, general questions regarding claims processing, or Healthy Options?

Provider Relations Unit
(800) 562-6188

Private insurance or third party liability, other than Healthy Options?

Coordination of Benefits Section
(800) 562-6136

Electronic Billing?

Write/call:
Electronic Billing Unit
PO Box 45511
Olympia, WA 98504-5511
(360) 725-1267

Who do I contact for more information regarding the Office of the Superintendent of Public Instruction Special Education Program?

Write/call:
Special Education
Old Capitol Building
PO Box 47200
Olympia, WA 98504-7200
Phone: (360) 753-6733
Fax: (360) 586-0247
TTY: (360) 664-3631
e-mail: speced@ospi.wednet.edu

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Definitions

This section defines terms and acronyms used throughout these billing instructions.

Client – An applicant approved for, or recipient of, DSHS medical care programs.

Code of Federal Regulations (CFR) - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

Community Services Office (CSO) - An office of the DSHS which administers social and health services at the community level.

Core Provider Agreement - The basic contract that MAA holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation in Medical Assistance.

Cost-Based Reimbursement - A payment method by which providers are reimbursed for services based on the cost of providing those services. Cost-based reimbursement rates are adjusted annually.

Department - The state Department of Social and Health Services.

Encounter - An encounter is a face-to-face contact between a client and a provider of health care services who exercises independent judgement in the provision of health services to the individual client. (For a health service to be defined as an encounter, it must meet the specific encounter criteria and provision of the health service must be recorded in the client's record.)

Explanation of Benefits (EOB) - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

Focus of Concern (FOC) or Referral - A report which includes a description of a student's suspected disabilities.

Individualized Education Program (IEP) - An individual education plan for students who have disabilities and/or special education needs. The plan is developed by a school district and the student's parents/legal guardians and includes classroom goals and objectives as well as a plan for providing services to the student. The plan can be revised at the request of either the student's parents/legal guardians or teacher. It is reviewed annually and revised as necessary.

Individualized Family Services Plan (IFSP) - A plan which addresses the family needs for the care of a child with a disability. An IFSP may also include an Individualized Education Program (IEP).

Managed Care – A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

Maximum Allowable - The maximum dollar amount a provider may be reimbursed by MAA for specific services, supplies, or equipment.

Medicaid - The state and federal funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

Medical Assistance Administration (MAA) - The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

Medical Assistance IDentification (MAID) cards – MAID cards are the forms DSHS uses to identify clients of medical programs. MAID cards are good only for the dates printed on them. Clients receive a MAID card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were previously known as DSHS medical coupons.

Medically Necessary - A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

Patient Identification Code (PIC) - An alphanumeric code that is assigned to each MAA client consisting of:

a) First and middle initials (a dash (-) must be used if the middle initial is not indicated).
b) Six-digit birthdate, consisting of *numerals only* (MMDDYY).
c) First five letters of the last name (and spaces if the name is fewer than five letters).
d) Alpha character (tiebreaker).

Program Support, Division of (DPS) – The division within MAA responsible for providing administrative services for the following:

- Claims Processing;
- Family Planning Services;
- Administrative Match Services to Schools and Health Departments;
- Managed Care Contracts;
- Provider Enrollment/Relations; and
- Regulatory Improvement.

Provider or Provider of Service - An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

Remittance and Status Report (RA) - A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

Revised Code of Washington (RCW) - Washington State laws.

Third Party - Any entity that is or may be liable to pay all or part of the medical cost of care of a federal Medicaid or state medical program client. (WAC 388-500-0005)

Title XIX - The portion of the federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

Usual and Customary Fee – The rate that may be billed to DSHS for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same.

Washington Administrative Code (WAC) - Codified rules of the state of Washington.

School Medical Services For Special Education Students

About the Program

School medical services for special education students may be diagnostic, evaluative, or rehabilitative in nature, and must be based on a child's medical needs. These medically necessary services must be identified in the child's:

- **Referral** to determine or ensure a child's potential for participation in an Individualized Education Program (IEP) or Individualized Family Services Plan (IFSP); **and/or**
- IEP or IFSP.

Parent Notification and Consent

Confidentiality regulations relating to special education services require districts to obtain a signed consent letter for the parent(s) or legal guardian(s) of each student for whom the district will be billing MAA. A copy of this form letter in English, Spanish, Russian, Korean, Cambodian, or Vietnamese may be obtained by contacting the Office of the Superintendent of Public Instruction (OSPI), Special Education Program (see *Important Contacts*). You may download an electronic version of this form (English only) by visiting the OSPI website at http://www.k12.wa.us/specialed/document.asp, State Forms for Special Education link.

Licenses, Certificates, and Practitioner Qualifications

Services must be provided by licensed/certified/classified personnel. Districts must list each provider in MAA's core provider agreement and notify MAA's Provider Relations Unit of changes to this list (see *Important Contacts*). Each provider must meet MAA qualifications.

Districts must document each service provider's qualifications. Documentation must show whether the service was provided by a licensed or certified practitioner or by persons trained or supervised by a licensed/certified practitioner (e.g., aides, nurse assistants, and aides and assistants for occupational, physical or speech therapies).

Client Eligibility

Who is eligible?

- Clients presenting Medical IDentification (ID) cards with the following identifiers are eligible to receive School Medical Services for Special Education Students:

Medical Program Identifier	Medical Program Name
CNP	Categorically Needy Program
LCP-MNP	Limited Casualty Program-Medically Needy Program

- Children verified as eligible on the eligibility match list provided by the Office of the Superintendent of Public Instruction (OSPI) are eligible for school medical services.

Who is not eligible?

Clients presenting Medical ID cards with the following identifiers are not eligible for school medical services:

Medical Program Identifier	Medical Program Name
CNP – CHIP	Categorically Needy Program – Children's Health Insurance Program
CNP- Emergency Medical Only	Categorically Needy Program – Emergency Medical Only
CNP-QMB	Categorically Needy Program – Qualified Medicare Beneficiary
Detox Only	DETOX
Family Planning Only	Family Planning Only
GAU - No Out of State Care	General Assistance Unemployable
General Assistance – No Out of State Care	ADATSA, ADATSA Medical Only
LCP-MNP Emergency Medical Only	Limited Casualty Program-Medically Needy Program Emergency Medical Only
MIP-EMER Hospital Only – No out-of-state care	Medically Indigent Program
QMB-Medicare Only	Qualified Medicare Beneficiary-Medicare Only

How is eligibility for school medical services determined?

As a first step in determining Medicaid eligibility, districts must give OSPI a listing of all students receiving or being evaluated for special education services. Submit this list monthly to OSPI and include the student's full name, birthdate, and social security number, if available. OSPI consolidates all district lists and submits a combined list to MAA for a Medicaid eligibility match.

To verify eligibility, MAA furnishes OSPI with the following information:

- Social Security Number (SSN), when provided by the district;
- Name of the Medicaid client;
- MAA-generated Patient Identification Code (PIC);
- Dates of Medicaid eligibility (up to five periods of eligibility will be provided);
- Address of the Medicaid client. This can be used by districts to indicate whether the "matched" Medicaid client is the student being served by that district. For example, if the address for the Medicaid "matched" child is Spokane and the child is being served by a Tacoma district, the Tacoma district may determine this to be the same child if its records indicate the child just moved into its district from Spokane;
- Birth date and sex of the Medicaid client; and
- Third-party insurance information for clients who are privately insured. **Districts may choose not to bill Medicaid for special education students who have third-party insurance coverage.**

Go to MAA's website at http://maa.dshs.wa.gov, Billing Instructions link to download a copy of MAA's General Information Booklet for a guide to information on the Medical ID card.

Are managed care clients eligible for MAA-reimbursable school medical services?

Healthy Options

Yes. Clients with an identifier in the HMO column on their Medical ID card are enrolled in one of MAA's Healthy Options managed care plans. If a child is enrolled in an MAA Healthy Options managed care plan, MAA pays for services provided in the schools that are part of the IEP/IFSP. Bill MAA directly for these services.

Privately Purchased

No. Treat privately purchased managed health care coverage as any other third-party insurance. Privately purchased managed health coverage will be listed in the column titled TPL (Third-Party Liability) in the MAA/OSPI eligibility match list.

Covered Services and Procedures

Physical Therapy

Listed below are descriptions of covered physical therapy services.

Muscle Testing

- Muscle testing, manual:

  - ✓ Extremity (excluding hand) or trunk, with report;
  - ✓ Hand (with or without comparison with normal side); and
  - ✓ Total evaluation of body, including hands.

- Range of motion measurements and report:

  - ✓ Each extremity, excluding hand; and
  - ✓ Hand, with or without comparison with normal side.

Modalities

- Physical medicine treatment to one area;
- Whirlpool; and
- Visit with one treatment/modality.

Procedures

- Physical medicine treatment to one area, each visit:

  - ✓ Therapeutic exercises;
  - ✓ Neuromuscular reeducation;
  - ✓ Functional activities;
  - ✓ Gait training;
  - ✓ Traction, manual;
  - ✓ Massage; and
  - ✓ Unlisted procedure (specify).

Therapies And Evaluation

- Pool therapy or Hubbard tank with therapeutic exercises, each visit;
- Manipulation (cervical, thoracic, lumbosacral, sacroiliac, hand, wrist), one area;
- Orthotics training (dynamic bracing, splinting), upper and/or lower extremities, each visit;
- Prosthetic training, each visit;
- Kinetic activities to increase coordination, strength and/or range of motion, one area (any two extremities or trunk), each visit; and
- Training in activities of daily living (self care skills and/or daily life management skills), each visit.

Combination Modalities/Procedures

- Visit including a combination of any modality(ies) and procedure(s).

Tests and Measurements

- Student assessment and evaluation by a therapist, initial or reevaluation;
- Custom splints (cock-up and/or dynamic);
- Visit, including one of the following tests or measurements, with report:

  ✓ Orthotic "check-out";
  ✓ Prosthetic "check-out"; and
  ✓ Activities of daily living "check-out";

- Extremity testing for strength, dexterity or stamina, each visit;
- Muscle testing with torque curves during isometric and isokinetic exercise, mechanized or computerized evaluations with printout;
- Durable medical equipment needs assessment (e.g., need for wheelchair, positioning equipment, orthotics);
- Fabrication of positioning equipment, upper or lower extremities;
- Orthotics, prefabricated or fabricated for lower or upper extremities, per extremity;
- Unlisted physical medicine service or procedure;
- Time involved in fabrication of positioning equipment, 15-minute increments; and
- Time involved for fitting and positioning of orthotics (prefabricated or fabricated) per extremity, 15-minute increments.

Procedure Code	Description
Physical Therapy	
0135S	Individual physical therapy services
0140S	Group physical therapy services

Speech Therapy

Listed below are descriptions of covered speech therapy services.

- Medical evaluation of speech, language, and/or hearing problems;
- Speech, language, or hearing therapy for an individual; and
- Speech, language, or hearing therapy within a group.

Procedure Code	Description
Speech Therapy	
0145S	Individual speech therapy services
0150S	Group speech therapy services

Audiology

Listed below are descriptions of covered audiology services.

- Screening test, pure tone, air only;
- Pure tone audiometry (threshold):

  ✓ Air only; and
  ✓ Air and bone;

- Speech audiometry:

  ✓ Threshold only; and
  ✓ Threshold and discrimination;

- Basic comprehensive audiometry, (pure tone, air and bone, and speech; threshold and discrimination);
- Tympanometry (impedance testing);
- Acoustic reflex testing;
- Conditioning play audiometry, pediatric audiometry; and
- Central auditory function test(s) (specify).

Procedure Code	Description
Audiology	
0110S	Audiology services

Psychological Evaluation

Psychological evaluation includes a complete diagnostic history and examination. Testing may be included, if appropriate.

Procedure Code	Description
Psychological Evaluation	
0120S	Psychological evaluation

Nurse Services

Listed below are descriptions of covered nurse services.

- Catheterization;
- Nasal gastric or gastrostomy tube feeding;
- Positioning and range-of-motion exercises;
- Manipulation of chest wall (e.g., suctioning, clapping, postural drainage, administration of inhaled medications);
- Dressing/wound care;
- Stoma care;
- Administration of parenteral medications;
- Administration of nourishment through intravenous catheter;
- Seizure care;
- Blood glucose determination;
- Oxygen administration;
- Nebulizer treatment;
- Nursing assessment;
- Seizure medication monitoring; and
- Medically necessary observations for adverse reactions (e.g., oral medications, self-catheterizations, etc.).

Procedure Code	Description
Nurse Services	
0115S	Nursing Services

Occupational Therapy

Listed below are descriptions of covered occupational therapy services.

- **Occupational therapy assessment:**

  - ✓ Fine motor skills;
  - ✓ Gross motor skills;
  - ✓ Muscle tone;
  - ✓ Range of motion;
  - ✓ Reflex and righting reactions;
  - ✓ Assessment of movement patterns;
  - ✓ Administration of standardized developmental testing;
  - ✓ Oral-motor assessment;
  - ✓ Visual motor skills;
  - ✓ Visual perception skills; and
  - ✓ Activities of daily living skills.

- **Occupational therapy:**

  - ✓ Neurodevelopmental therapy for motor skills;
  - ✓ Exercises for relaxation;
  - ✓ Oral-motor exercise for feeding;
  - ✓ Exercises for fine or gross motor skills;
  - ✓ Exercises for improving overall body strength and coordination;
  - ✓ Passive and active range of motion exercises; and
  - ✓ Exercises for improving muscle tone and improving movement patterns;

- Durable medical equipment needs assessment (e.g. need for wheelchair, positioning equipment, orthotics);
- Fabrication of positioning equipment for upper or lower extremities;
- Orthotics, prefabricated or fabricated, for lower or upper extremities; per extremity;
- Time involved in fabrication of positioning equipment, 15-minute increments; and
- Time involved for fitting and positioning of orthotics (prefabricated or fabricated) per extremity, 15-minute increments.

Procedure Code	Description
Occupational Therapy	
0125S	Individual occupational therapy services
0130S	Group occupational therapy services

Counseling Services

Counseling services include individual and group counseling which is directed at health, social, and emotional concerns of the student. These counseling services EXCLUDE academic, vocational, career, and general guidance counseling/advising.

Procedure Code	Description
Counseling Services	
0155S	Individual counseling
0160S	Group counseling

☞ **Note:** Counseling services provided by the school district, as prescribed in the IEP or IFSP, do not relinquish the Regional Support Networks (RSNs)/Prepaid Health Plans (PHPs) from their responsibilities to provide medically necessary mental health services to children in need of these services. School districts, mental health providers, and other health related providers should make every effort to collaborate on meeting students' health related needs.

Direct Service Encounters

MAA has established a special procedure code to use on the HCFA-1500 claim form for claiming the total number of direct service encounters that a district provides to a Medicaid-eligible student in a month. The instructions on completing the HCFA-1500 claim form (see page 25) outline how to use this procedure code.

Procedure Code	Description
Direct Service Encounters	
0170S	Direct Service Encounters

☞ **Note:** You must bill these direct service encounters as encounters only. Reimbursement is at the MAA usual and customary rate per encounter, and is not calculated in 15-minute intervals. The encounter procedure code must be billed in conjunction with the services that are provided. Do not submit claims with only 0170S on them.

Provider Requirements

Physical Therapy

Listed below are professional guidelines for providing physical therapy services.

- Services must be performed by:

  - ✓ A licensed physical therapist or a physiatrist;
  - ✓ A physical therapy assistant who is under the supervision of a licensed physical therapist; or
  - ✓ A person trained and supervised by a licensed physical therapist.

- Physical therapy services must be recommended by:

  - ✓ A registered nurse;
  - ✓ Physical therapist;
  - ✓ Physiatrist;
  - ✓ Advanced registered nurse practitioner; or
  - ✓ Physician.

  ☞ **Note: The recommendation must be updated at least annually.** For documenting recommendations from physical therapists, the child's record should include a statement such as, "Recommended by the physical therapist and consistent with the IEP or IFSP."

- All license requirements set by specialty boards apply to physical therapy services provided to special education students through the School Medical Services program.

Speech Therapy

Listed below are professional guidelines for providing speech therapy services.

- Services must be *performed* by:

  - ✓ A speech pathologist or audiologist who has been granted a Certificate of Clinical Competence by the American Speech, Language and Hearing Association;
  - ✓ A person who has completed the equivalent educational and work experience necessary for such a certificate;
  - ✓ A person trained and supervised by a qualified person as described above; OR
  - ✓ A person who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

- Speech services must be *recommended* by:

  - ✓ A person who has been granted a Certificate of Clinical Competence by the American Speech, Language and Hearing Association;
  - ✓ A person who has completed the equivalent educational and work experience necessary for such a certificate;
  - ✓ An advanced registered nurse practitioner; OR
  - ✓ A physician.

☞ **Note: The recommendation must be updated at least annually**. For documenting recommendations from speech therapists, the child's record should include a statement such as: "Recommended by the speech therapist and consistent with the IEP or IFSP."

Audiology

Listed below are professional guidelines for providing audiology services.

- Services must be *performed* by:

  - ✓ A speech pathologist or an audiologist who has been granted a Certificate of Clinical Competence by the American Speech, Language and Hearing Association;
  - ✓ A person who has completed the equivalent educational and work experience necessary for such a certificate;
  - ✓ A person trained and supervised by a qualified person as described above; OR
  - ✓ A person who has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

- Audiology services must be *recommended* by:

  - ✓ A person who has been granted a Certificate of Clinical Competence by the American Speech, Language and Hearing Association;
  - ✓ A person who has completed the equivalent educational and work experience necessary for such a certificate;
  - ✓ An advanced registered nurse practitioner; OR
  - ✓ A physician.

  ☞ **Note: The recommendation must be updated at least annually**. For documenting recommendations from audiologists, the child's record should include a statement such as: "Recommended by the audiologist and consistent with the IEP or IFSP."

- *Calibrated electronic equipment* must be used; and
- Reimbursement is not allowed for *routine* or *group* screenings.

Psychological Evaluation

Listed below are professional guidelines for providing psychological evaluations.

- Psychological evaluations must be *performed* by:

  - ✓ A psychologist who is licensed in the State of Washington; or
  - ✓ A school psychologist who has been granted an Educational Staff Associate (ESA) certificate.

- Psychological evaluations must be *recommended* by:

  - ✓ A school psychologist who has been granted an Educational Staff Associate (ESA) certificate; or
  - ✓ A licensed practitioner (e.g., a registered nurse, an advanced registered nurse practitioner, a physician or a psychologist licensed in the State of Washington).

  ☞ **Note: The recommendations must be updated at least annually**. For documenting recommendations from ESA-certified psychologists, the student's record should include a statement such as, "Recommended by the ESA-certified psychologist and consistent with the IEP or IFSP."

- All license requirements set by specialty or certification boards apply to psychological evaluations provided to special education students through the School Medical Services program.

Nurse Services

Listed below are professional guidelines for providing nurse services.

- Services must be *performed* by:

  - ✓ A licensed registered nurse (RN); or
  - ✓ A person trained and supervised by a licensed RN.

- Nursing services must be *recommended* by:

  - ✓ A licensed registered nurse (RN);
  - ✓ Advanced registered nurse practitioner; or
  - ✓ A physician.

> ☞ **Note: The recommendation must be updated at least annually**. For documenting recommendations from nurses, the student's record should include a statement such as, "Recommended by the nurse and consistent with the IEP or IFSP."

- All license requirements set by specialty boards apply to Nurse Services provided to special education students through the School Medical Services program; and
- Based on license requirements and other state regulations, school nurses will ensure that physician orders are obtained as needed, including orders for administering IVs and injections.

Occupational Therapy

Listed below are professional guidelines for providing occupational therapy services.

- Services must be *performed* by:

  - ✓ A licensed occupational therapist;
  - ✓ A licensed occupational therapy assistant who is supervised by a licensed occupational therapist; or
  - ✓ A person trained and supervised by a licensed occupational therapist.

- Occupational therapy services must be *recommended* by:

  - ✓ A registered nurse;
  - ✓ An occupational therapist;
  - ✓ An advanced registered nurse practitioner; or
  - ✓ A physician.

☞ **Note: The recommendation must be updated at least annually.** For documenting recommendations from occupational therapists, the student's record should include a statement such as, "Recommended by the occupational therapist and consistent with the IEP or IFSP."

- All license requirements set by specialty boards apply to occupational therapy services provided to special education students through the School Medical Services program.

Counseling Services

Listed below are professional guidelines for providing counseling services.

- Counseling services must be *performed* by:

  - ✓ A school psychologist who has been granted an Educational Staff Associate (ESA) certificate;
  - ✓ A school guidance counselor who has been granted an ESA certificate;
  - ✓ A school social worker who has been granted an ESA certificate; or
  - ✓ A psychologist who is licensed in the state of Washington.

- Counseling services must be *recommended* by:

  - ✓ A school psychologist who has been granted an Educational Staff Associate (ESA) certificate; or
  - ✓ A licensed practitioner (e.g., a registered nurse, an advanced registered nurse practitioner, a physician or a psychologist licensed in the state of Washington).

☞ **Note: The recommendation must be updated at least annually.** For documenting recommendations from ESA-certified psychologists, the student's record should include a statement such as, "Recommended by the ESA-certified psychologist and consistent with the IEP or IFSP."

- All license requirements set by specialty or certification boards apply to counseling services provided to special education students through the School Medical Services program.

Reimbursement

MAA's reimbursement rates to school districts for health-related services provided to Medicaid-eligible students are based on the cost of providing the services.

MAA establishes reimbursement rates every third year, based upon cost data received from OSPI. Only minimal information is obtained directly from school districts. For intervening years, cost of living adjustments are applied to the rates.

MAA may reimburse for services if the:

- Student is being evaluated for or is receiving special education services;
- Student is receiving medically necessary services as a part of his/her evaluation or special education plan;
- Student is Medicaid eligible as determined by MAA; **and**
- Student's parent(s) or legal guardian(s) have been notified of and have given consent for the reimbursement process.

MAA reimburses billed services for eligible clients based on the total amount of billable time spent on the service by the service provider. Service providers must bill time in 15-minute units; all partial units must be rounded up. For documentation purposes, service providers may track billable time in actual, total time (minutes/hours).

For example, a 52-minute whirlpool would be figured like this:

1-15 minutes	=	1 unit
16-30 minutes	=	1 unit
31-45 minutes	=	1 unit
46-52 minutes	=	1 unit
Total units	**=**	**4 units**

In tracking and billing time, providers may consider the following in the calculation of billable time:

- Direct hands-on service;
- Preparation (e.g., equipment set up);
- Report writing;
- Consultations (e.g., with other professionals);
- Travel between service delivery sites (schools); and
- Any other activity related to the service being billed to Medicaid which can be attributed to the individual child being served.

MAA reimburses the Office of the Superintendent of Public Instruction (OSPI) directly for medical services provided by a school district, an educational service district, or a special education cooperative. School districts must reassign Medicaid payments to OSPI. Districts must complete and sign an authorization for payment reassignment. OSPI will then reapportion the share of the Medicaid payments to the respective school districts.

OSPI reimburses DSHS from its state appropriations for the state portion of Medicaid payments made by DSHS for services provided under an IEP or IFSP to special education students. (The percent of state dollars in Medicaid payments changes every October 1 with the new federal fiscal year). The reimbursement is deducted by OSPI as an allocation to districts for handicapped education programs.

DISCLAIMER

A school district, which bills Medicaid, must accept responsibility for all disallowances and/or penalties that the federal Health Care Financing Administration (HCFA) may determine during an audit of the district's special education-related Medicaid claims.

Medicaid Payments - Federal/State Dollars

Date	Federal Dollars	State Dollars
10/1/99 - 9/30/00	51.83%	48.17%
10/1/00 – 9/30/01	50.70%	49.30%

Procedure Codes

All services billed to MAA are paid based on the amount of billable time spent by the provider of the services with the client. Billable time is billed in 15-minute units. All fractions of a unit must be rounded up to the next whole unit. Each school district receives individual rates based on the cost-reimbursement methodology.

Procedure Code	Description
Physical Therapy	
0135S	Individual physical therapy services
0140S	Group physical therapy services
Speech Therapy	
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0170S	Direct Service Encounters

☞ **Note:** You must bill procedure code 0170S in conjunction with the services that are provided. Do not submit claims with only 0170S on them.

General Billing

☞ **Note:** This section pertains to general MAA billing. Not all information necessarily applies to the School Medical Services for Special Education Students program.

What is the time limit for billing? (Refer to WAC 388-502-0150)

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to submit an **initial claim** to MAA and obtain an ICN within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

[1] **Delayed Certification:** A person applies for a medical program prior to the month of service and a delay occurs in the processing of the application. Because of this delay, the eligibility determination date becomes later than the month of service. A delayed certification indicator will appear on the MAID card. The provider **MUST** refund any payment(s) for a covered service received from the client for the period he/she is determined to be medical assistance-eligible, and then bill MAA for those services.

- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:
  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to MAA's satisfaction that there are other extenuating circumstances.
- ✓ MAA requires providers to bill known third parties for services. See WAC 388-501-0200 for exceptions. Providers must meet the timely billing standards of the liable third parties, in addition to MAA's billing limits.

- **Resubmitted Claims**

  - ✓ Providers may resubmit, modify, or adjust any timely initial claim, except prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the allotted time period listed above.

The allotted time periods do not apply to overpayments that the provider must refund to DSHS. After the allotted time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument such as a bank check.

The provider, or any agent of the provider, must not bill a client or a client's estate when:

- The provider fails to meet these listed requirements; and
- MAA does not pay the claim.

What fee should I bill MAA for eligible clients?

MAA has established rates for school districts based on a cost-based reimbursement system for each individual district. Districts should use these rates to bill MAA for services provided to MAA-eligible, special education students.

[2] **Retroactive Certification:** An applicant receives a service, then applies to MAA for medical assistance at a later date. Upon approval of the application, the person was found eligible for the medical service at the time he or she received the service. The provider **MAY** refund payment made by the client and then bill MAA for the service. If the client has not paid for the service and the service is within the client's scope of benefits, providers must bill MAA.

Third-Party Liability

> ☞ **Note:** Districts may choose not to bill MAA for special education students who have other third-party insurance

The Office of the Superintendent of Public Instruction (OSPI) provides school districts with third-party insurance coverage information for special education students. The district may choose not to bill MAA for services provided to children who have third-party insurance. School districts are *not* required to pursue third-party reimbursement when MAA is not being billed. If a district chooses to bill MAA for students with third-party insurance coverage, the district must:

- Bill these carriers before billing MAA; and

- Request, in writing, consent from the student's parent(s)/guardian(s) to bill the student's insurance carrier before billing the carrier. This letter should clearly state the conditions and consequences of this billing program as referenced in RCW 74.09.5249.

When MAA is being billed:

- If the insurance reimbursement amount is *less than the MAA maximum allowance*, or the charges are denied by an insurance company, you should rebill the claim to MAA. You will need to attach a copy of the insurance company's Eligibility of Benefits (EOB) when you rebill.

- If you bill MAA because the third party paid less than the MAA allowed amount, and MAA *denies the service*, you must accept the third-party payment as payment in full.

You must bill the insurance carrier(s) indicated on the client's MAID card. An insurance carrier's time limit for claim submissions may be different from MAA's. It is your responsibility to meet the insurance carrier's requirements relating to billing time limits, as well as MAA's, prior to any payment by MAA.

You must meet MAA's 365-day billing time limit even if you haven't received notification of action from the insurance carrier. If your claim is denied due to any existing third-party liability, refer to the corresponding MAA Remittance and Status Report for insurance information appropriate for the date of service.

If you receive an insurance payment and the carrier pays you less than the maximum amount allowed by MAA, or if you have reason to believe that MAA may make an additional payment:

- Submit a completed claim form to MAA;
- Attach the insurance carrier's statement or EOB;
- If rebilling, also attach a copy of the MAA Remittance and Status Report showing the previous denial; or
- If you are rebilling electronically, list the claim number (ICN) of the previous denial in the comments field of the Electronic Media Claim (EMC).

Third-party carrier codes are available on MAA's website at http://maa.dshs.wa.gov or by calling the Coordination of Benefits Section at 1-800-562-6136.

What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years[3] from the date of service or more if required by federal or state law or regulation.**

[3] WAC 388-502-0020, filed 8/00, sets a six-year record retention requirement for all MAA providers. The WAC establishes a time frame for records that is significantly longer than the direction previously given to school districts. MAA expects school districts to move toward compliance and retain records for the longer period of time.

How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). **Some field titles may not reflect their usage for this claim type.** The numbered boxes on the claim form are referred to as fields.

General Instructions

- Please use an original, red and white HCFA-1500 (U2) (12-90) claim form.
- Enter only one (1) procedure code per detail line (field 24A-24K). If you need to bill more than six (6) lines per claim, please complete an additional HCFA-1500 claim form.
- You must enter all information within the space allowed.
- Use upper case (capital letters) for all alpha characters.
- Do not write, print, or staple any attachments in the bar area at the top of the form.

FIELD **DESCRIPTION**

1a **Insured's I.D. No**.: Required. Enter the Medicaid Student (client) Identification Code (PIC) – an alphanumeric code assigned to each MAA client. This information is obtained from the eligibility list from OSPI or the client's current monthly Medical Assistance IDentification (MAID) card. The PIC consists of:

a) First and middle initials (a dash [-] must be used if the middle initial is not available).
b) Six-digit birthdate, consisting of numerals only (MMDDYY).
c) First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tiebreaker.
d) An alpha or numeric character (tiebreaker).

For example: **JA101285SMITHA**

2. **Patient's Name**: **Recommended.** Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

5. **Patient's Address**: **Optional.** Enter the address of the MAA client who has received the services you are billing for (the person whose name is in *field 2*.)

9. **Other Insured's Name**: Secondary insurance. When applicable, enter the last name, first name, and middle initial of the insured. If the client has insurance secondary to the insurance listed in *field 11*, enter it here.

9a. Enter the other insured's policy or group number *and* his/her Social Security Number.

9b. Enter the other insured's date of birth.

9c. Enter the other insured's employer's name or school name.

9d. Enter the insurance plan name or the program name (e.g., the insured's health maintenance organization, private supplementary insurance).

Please note: DSHS, Welfare, Provider Services, Healthy Kids, First Steps, and Medicare, etc., are inappropriate entries for this field.

17. **Name of Referring Physician or Other Source**: **Optional.** Enter the referring physician for physical therapy and occupational therapy sessions.

24. **Enter only one (1) procedure code per detail line (fields 24A - 24K). If you need to bill more than six (6) lines per claim, please use an additional HCFA-1500 claim form**.

24A. **Date(s) of Service**: **Required.** For each procedure code being billed, enter the first day of the month for which you are billing in the *From* section. Enter the last day of that month in the *To* section. This allows all charges during one month for one procedure code to be billed on one line. **When billing multiple months of service, use a separate line for each month.** Enter dates numerically (e.g., September 1, 2000 = 090100). Do not use slashes, dashes or hyphens to separate month, day, year - MMDDYY.

24B. **Place of Service**: **Required.** These are the only appropriate code(s) for Washington State Medicaid:

Code Number	To Be Used For
3	School
4	Student's residence

24C. **Type of Service**: **Required.** Enter a **3** for all services billed.

24D. **Procedures, Services or Supplies CPT/HCPCS**: **Required.** Enter the appropriate procedure code for the services being billed. Use one line for each procedure code being billed that month. Remember to reserve one line to record the number of encounters being billed.

24E. **Diagnosis Code**: **Required. Enter V41.9**, unspecified problem with special functions.

24F. **$ Charges**: **Required.** Enter the total amount charged. (Calculate the amount using the district-specific, Cost-Based Rate for each procedure code multiplied by the number of billable units.) If more than one unit is being billed, the charge shown must be for the total of the units billed. Do not include dollar signs or decimals in this field.

24G. **Days or Units**: **Required.** For each procedure code, enter the total number of billable units (up to 999) for the month being billed. (15 minutes = 1 unit). Round up all fractions of units.

☞ **Please Note:** When the procedure code in *field 24D* is **0170S** (number of direct service encounters), enter the total number of "hands-on," direct service encounters with the special education student for all procedure codes being billed on that HCFA-1500 claim form.

26. **Your Patient's Account No.**: **Optional.** Enter the student's number or other identifying number. This is any nine-digit alphanumeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report.

28. **Total Charge**: **Required.** Enter the sum of your charges. Do not use dollar signs or decimals in this field.

29. **Amount Paid**: *If you receive an insurance payment or patient paid amount,* show that amount here, and attach a copy of the insurance EOB. Do not use dollar signs or decimals in this field.

30. **Balance Due**: **Required.** Enter balance due. Enter total charges minus any amount(s) in *field 29*. Do not use dollar signs or decimals in this field.

33. **Physician's, Supplier's Billing Name, Address, Zip Code and Telephone #**: **Required.** Put the *Name, Address,* and Telep*hone #* of your district on all claim forms.

Group: Enter the seven-digit provider number assigned to your district by the MAA after you submitted your Core Provider Agreement.

Sample HCFA-1500 Claim Form